

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **SHAHZAD HASAN, M.D.**

4 Holder of License No. 33716
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-08-0095A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**
(Letter of Reprimand)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on
8 December 4, 2008. Shahzad Hasan, M.D., ("Respondent") appeared before the Board for a
9 formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board
10 voted to issue Findings of Fact, Conclusions of Law and Order after due consideration of the facts
11 and law applicable to this matter.

12 **FINDINGS OF FACT**

13 1. The Board is the duly constituted authority for the regulation and control of the
14 practice of allopathic medicine in the State of Arizona.

15 2. Respondent is the holder of License No. 33716 for the practice of allopathic
16 medicine in the State of Arizona.

17 3. The Board initiated case number MD-08-0095A after receiving a complaint
18 regarding Respondent's care and treatment of a 36 year-old female patient ("SK") alleging
19 Respondent failed to monitor SK's PT/INR results and failed to respond to her deteriorating
20 condition that contributed to her death.

21 4. SK was a 36 year old female with an extensive past medical history, which
22 included spina bifida, lower extremity paraplegia, mild chronic renal insufficiency with nephrotic
23 range proteinuria, recurrent UTI's and urostomy status, central sleep apnea on CPAP, and a prior
24 VP shunt placement, who was on Coumadin for DVT prophylaxis. .
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1 5. SK had an INR performed as an outpatient on the morning of March 2, 2007 that
2 was critically elevated.

3 6. SK was transmitted to Del Webb Hospital by EMS the evening of March 2, 2007
4 with decubitus ulcer bleeding; however, there was no documentation that the ER physician was
5 aware of her critical INR value.

6 7. Multiple labs were ordered except for a PT/INR. SK was admitted early the next
7 morning with a decubitus ulcer and UTI. A chest x-ray was performed and showed worsening of
8 interstitial prominence-infiltrate or edema, when compared to a prior film. Verbal orders were
9 received from a covering provider for plastic surgery and infectious disease consultations.

10 8. SK was seen by the plastic surgeon who wrote wound care orders and also
11 ordered a Clinitron bed and heel pads. Bedside debridement was performed.

12 9. Respondent saw SK for the first time in the morning of March 3, 2007 and
13 documented a chief complaint of "decubitus getting worse". On exam, Respondent documented
14 SK's paralysis, but indicated that he did not examine the decubitus because SK had difficulty
15 rolling to the side.

16 10. Respondent noted that a PT/INR had not been ordered and gave a 'Now' order to
17 obtain the lab at 10:35am that same day. He additionally started intravenous fluids.

18 11. SK was seen by the infectious disease specialist who ordered IV Cefepime for the
19 UTI. In the afternoon, SK received IV Morphine for reported back pain.

20 12. Respondent left the hospital at approximately 5:00 pm on March 3, 2007.

21 13. In the late afternoon of March 3, 2007, SK was noted to have sleep apnea, a
22 reduced respiratory rate, and required nasopharyngeal suctioning of small amounts of red colored
23 fluid.

1 14. At approximately 6:30 pm, nursing staff called Respondent and updated him
2 regarding CK's condition. He gave verbal orders to administer Narcan, which improved her
3 respiratory rate, and to discontinue Morphine.

4 15. At 7:00 pm, a nurse updated Respondent regarding SK's status. The nurse noted
5 that respiratory therapy documented hypoxia on a 50% VM and suctioning of large amounts of
6 bloody secretions. SK was placed on a 100% NRB mask. Nursing notes described SK as
7 obtunded. Respondent gave new lab orders at this time, but did not return to the hospital to see
8 the patient...

9 16. Labs were drawn at 9:45 pm and the lab values reported were a critical K+ of 6.6,
10 a PT of greater than 80, and an INR greater than 20. After being contacted, Respondent gave
11 verbal orders for ICU transfer, treatment of hyperkalemia, Vitamin K and renal consultation.

12 17. SK was subsequently transferred to the ICU with copious amounts of bright red
13 blood pouring from her nose and mouth. She had agonal breathing and was pulseless and a code
14 arrest was called.

15 18. At 12:00am, March 4, 2007, Respondent arrived back at the hospital with the code
16 in progress and spoke with the family. Resuscitation efforts were not successful and SK was
17 pronounced dead on March 4, 2007 at 1:23 a.m.

18 19. SK's final diagnoses included respiratory failure attributed to pneumonia/probable
19 aspiration, sepsis and septic shock, coagulopathy secondary to Coumadin and UTI.

20 20. During his Formal Interview Respondent admitted that he did not pursue the
21 PT/INR test that he had ordered, but relied on hospital staff to convey the information to him.

22 21. Respondent stated that he has changed his practice since this incident and is
23 more persistent in following up on orders that he gives.
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1 22. The standard of care for a covering hospitalist is to go and see a patient when
2 called repeatedly by nursing staff regarding worsened respiratory status, gurgling respiration,
3 apnea and bloody nasal secretions in a patient.

4 23. Respondent deviated from the standard of care by failing to go in and evaluate SK
5 personally when he was contacted repeatedly by nursing staff regarding her worsened respiratory
6 status.

7 24. The standard of care requires a physician to obtain a STAT PT/INR in a patient on
8 Coumadin who is admitted hypotensive and tachycardic with documentation of decubitus ulcer
9 bleeding and wound bleeding in emergency and EMS notes. It is up to the physician to contact
10 nursing staff or lab personnel if he/she has not been informed of the value in a timely manner.

11 25. Respondent deviated from the standard of care by failing to follow through on the
12 'Now' PT/INR order in a timely manner.

13 26. Respondent's conduct resulted in actual harm to the patient as she had apnea,
14 increased hypoxia and oxygen requirements, a worsened mental status and copious amounts of
15 bleeding from her nasal passages. She subsequently coded and died.

16 27. Respondent's use of standing orders that included strong narcotic analgesics and
17 oxygen as needed to maintain saturations above 93% may have contributed to SK's death, with
18 Morphine inducing apnea and nursing and respiratory staff responding by continuing to increase
19 the oxygen without additional provider orders.

20 **CONCLUSIONS OF LAW**

21 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof
22 and over Respondent.

23 2. The Board has received substantial evidence supporting the Findings of Fact
24 described above and said findings constitute unprofessional conduct or other grounds for the
25 Board to take disciplinary action.

1 3. The conduct and circumstances described above constitute unprofessional
2 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct that is or might be harmful or
3 dangerous to the health of the patient or the public.")

4 **ORDER**

5 Based upon the foregoing Findings of Fact and Conclusions of Law,

6 IT IS HEREBY ORDERED:

- 7 1. Respondent is issued a Letter of Reprimand.
- 8 2. The Board retains jurisdiction and may initiate new action based upon
9 any violation of this Order.

10 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

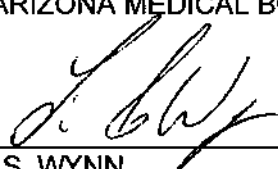
11 Respondent is hereby notified that he has the right to petition for a rehearing or review.
12 The petition for rehearing or review must be filed with the Board's Executive Director within thirty
13 (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review
14 must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103.
15 Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a
16 petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35)
17 days after it is mailed to Respondent.

18 Respondent is further notified that the filing of a motion for rehearing or review is required
19 to preserve any rights of appeal to the Superior Court.

20 DATE 5TH day of February, 2009.



21 THE ARIZONA MEDICAL BOARD

22 By 
23 LISA S. WYNN
24 Executive Director
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ORIGINAL of the foregoing filed this

1 5th day of February, 2009 with:

2 Arizona Medical Board
3 9545 East Doubletree Ranch Road
4 Scottsdale, Arizona 85258

4 Executed copy of the foregoing
mailed by U.S. Mail this
5 5th day of February, 2009 to:

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7 Shahzad Hasan, M.D.
8 Address of Record

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10 #236920

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